Methods: A retrospective case-note review of patients undergoing major colorectal surgery during a 4-month period at a single institution was undertaken. Lengths of hospital stay (LOS) were used as a surrogate marker for recovery and compared in 2 groups: those patients with an EWS $\geq$ 3 within the first 48 post-operative hours and those with scores of <3. These were compared using Student's t test.
Results: Sixty patients data were analysed of whom 19 (32.7%) had an EWS $\geq$3 within 48 hours of their surgery. For those with an EWS $\geq$3 the median LOS was 19 days (IQR 8-27) compared to 10 (IQR 7-19) for those with EWS <3 ($p = 0.0023$).
Conclusion: Patients undergoing major colorectal surgery who demonstrated EWS scores $\geq$3 in their first 48 post-operative hours required significantly longer LOS than those whose EWS scores were <3. Future work examining optimizing early post-operative physiology and its effects on recovery are needed.

0399: PATIENT FACTORS PREDICTING DELAYED DISCHARGE ON THE COLORECTAL ENHANCED RECOVERY PROGRAMME

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Aim: To identify preoperative patient factors associated with delayed discharge in Colorectal Enhanced Recovery Programme (ERP) patients.
Methods: Prospective data was collected between October 2013 and July 2014. Data included ASA grade, BMI, age, comorbidities and CR-POSSUM score, which was compared to length of stay. Delayed discharge was defined as from day four postoperatively.
Results: Data was collected on 50 patients. 75% of patients aged >80 suffered delayed discharge, compared to approximately 50% of patients aged $\leq$80.
57% of ASA grade 1–2 patients had delayed discharge, compared to 70% of ASA grade 3 patients. 66% of patients with BMI <25 were discharged within 3 days postoperatively, whereas only 34% of overweight patients and 36% of obese patients were discharged within this timeframe. Patients with three or more comorbidities were 50% more likely to have delayed discharge. There was no correlation between preoperative risk scoring and length of stay.
Conclusion: Factors most associated with delayed discharge were BMI >25, age greater than 80 years and having more than three comorbidities. ASA grade 3 was also associated with a delay in discharge. Such patients should be identified preoperatively and selected for higher-level care, in order to attempt to reduce length of stay.

0405: ADEQUACY OF PHOSPHATE ENEMA PREPARATION PRIOR TO FLEXIBLE SIGMOIDOSCOPY

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Aim: Incorporation of flexible sigmoidoscopy into the national bowel cancer-screening programme is expected by 2016. The purpose of this study was to identify completion rates and determine quality of preparation following phosphate enema versus oral bowel preparation prior to flexible sigmoidoscopy.
Methods: A retrospective study was undertaken of flexible sigmoidoscopies performed at City hospital, Birmingham. The outcome measures were the furthest point of insertion recorded, the splenic flexure and quality of bowel preparation.
Results: The study sample size was 508 patients (phosphate enema N = 240 and oral bowel preparation N = 268). The splenic flexure was identified in 39.3% of patients who underwent phosphate enema versus 49.4% in those who had oral bowel preparation ($p < 0.05$). Good quality preparation or better was seen in the phosphate enema group was 55.2% versus 51.7% in the oral bowel preparation group ($p < 0.05$).
Conclusion: Although oral bowel preparation resulted in increased completion rates, quality was similar. Further research is needed to determine optimum bowel preparation for best polyp detection rates.

0411: RE-AUDIT OF LOCALLY EXCISED STAGE 1 COLORECTAL CANCER MANAGEMENT IN A LARGE, TERTIARY REFERRAL CENTRE

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Aim: NICE guidelines (QS20:quality statement 5) require patients with locally excised stage 1 colorectal cancers, with resection margins less than 1mm, to be offered further surgery or active monitoring. A 2012 assessment demonstrated 100% adherence to QS20:quality statement 5 in this unit. This re-audit assessed performance in 2013.
Methods: Retrospective audit, across a large university health board. All colorectal cancers diagnosed in 2013 were extracted from a national database (CaNISC). Data points were collected from 'Welsh Clinical Portal' and 'ADAM' endoscopy records.
Results: In 2013, 338 patients were treated for colorectal cancer within the health board. Twelve polyp adenocarcinomas were removed by local excision - 4 underwent endoscopic mucosal resection (EMR), 1 laparoscopic-assisted EMR, 3 polypectomy and 4 transanal endoscopic microsurgery (TEMS). Ten of these were confirmed pT1. Six of the pT1 tumours had a resection margin <1mm (1.7%) and 5/6 had a resection status of R1 or greater. Following histological diagnosis, all 6 patients underwent multidisciplinary team review and all were offered active management. Three were managed with further surgery, three were managed conservatively.
Conclusion: We demonstrate 100% adherence to NICE guidelines for management of stage 1 colorectal cancers undergoing local excision within our health board during 2013.

0434: MULTICENTRE, RISK ADJUSTED COHORT STUDY ASSESSING THE EFFECT OF STATINS AND NSAIDS IN REDUCING COMPLICATIONS AFTER ABDOMINAL SURGERY

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Aim: Perioperative statin administration has been demonstrated to be effective in reducing complications in cardiovascular surgery. However, the role of statins within gastrointestinal (GI) surgery remains unclear.
Methods: This prospective, multicentre cohort study included consecutive patients undergoing GI resection. The effects of non-steroidal anti-inflammatory drugs (NSAIDs) or Statin administration were used to calculate adjusted odds ratios (OR and 95% confidence interval) using logistic regression and propensity score matching.
Results: Of all 1513 patients included, 443 received statins perioperatively. Patients receiving statins were substantially higher risk (ASA > 3, 28.24% vs. 52.37%, $P < 0.001$), but did not suffer significantly more postoperative complications (OR 0.94, 0.70–1.27), cardiovascular events (OR 1.01, 0.48–2.11) or anastomotic leak (OR 0.70, 0.35–1.34). After risk adjustment, patients on low dose statins (N = 188) demonstrated reductions in major complications (OR 0.58, 0.31–1.07) and anastomotic leak (OR 0.19, 0.04–0.62, $P < 0.05$). Co-administration of NSAIDs and statins (N = 54) was not associated with postoperative complications (OR 0.76, 0.42–1.39), cardiovascular events (OR 0.54, 0.03–2.97) or anastomotic leak (OR 1.98, 0.69–4.93).
Conclusion: Both NSAIDs and statins appear safe for use in the perioperative setting and may have a further role in reducing post-operative complications. Nevertheless, current observational evidence carries a high risk of bias. This data provides power for a randomised trial.

0437: ENGAGING THE MULTI-DISCIPLINARY TEAM CAN IMPROVE ADHERENCE TO ENHANCED RECOVERY GUIDELINES IN ELECTIVE COLORECTAL CANCER SURGERY

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Aim: Enhanced recovery (ERAS) guidelines recommend 28-day venous thrombo-emolism (VTE) prophylaxis with low-molecular weight heparin